Seniors...

Do you need help paying your medicine bills?

NEVADA'S seniorRx may be the solution!

Apply Now!

NEVADA'S seniorRx

Providing insurance subsidies for qualifying seniors

www.nevadaseniorrx.com

Tear along this perforation. Fold up completed application form, moisten glue strip and apply to edge indicated.

Nevada Department of Human Resources

Form SR Rx 7/01

Application for the State of Nevada • Prescription Insurance Subsidy Program

1. Applicant: _____

M ❑ F ❑ *Last Name, First, MI* *Birthdate* *Social Security #*

2. Spouse: _____

M ❑ F ❑ *Last Name, First, MI* *Birthdate* *Social Security #*

Is spouse applying for a subsidy? Yes ❑ No ❑

3. Residence Address: _____

Number, Street, Apt or Space Number, City/Town, State, Zip

4. Mailing Address: _____

Number, Street, Apt or Space Number, City/Town, State, Zip

5. Telephone Number: (_____)_____

6. Did you live in Nevada continuously 12 months prior to the date of this application?

Applicant: Yes ❑ No ❑ **Spouse:** Yes ❑ No ❑

List all current income received

*Spouse must list **monthly** income even if not applying for the prescription insurance subsidy program.*

	Applicant		Spouse		Total
7. Social Security (less Medicare).....	$_____	+	_____	=	_____
8. SSI (Supplemental Security Income)	$_____	+	_____	=	_____
9. Pensions/IRAS.....	$_____	+	_____	=	_____
10. Interest/Dividends.....	$_____	+	_____	=	_____
11. Wages.....	$_____	+	_____	=	_____
12. Net Real Estate Rental Income.....	$_____	+	_____	=	_____
13. Other (describe).....	$_____	+	_____	=	_____
Total Applicant & Spouse Monthy Income.....	$_____	+	_____	=	_____
14. Capital Gains (Loss) last year.....	$_____	+	_____	=	_____
15. Business Income (Loss) last year.....	$_____	+	_____	=	_____

Please provide monthly income, not annual income (except lines 14 and 15).

(Information provided on this application is confidential. No person may publish, disclose or use any personal or confidential information contained on this application except for the purposes connected with the administration of this program.)

Please read and sign below before completing this application.

By signing this application, I agree to the following:

- To immediately provide to the Department of Human Resources written notice of a change of address, name, household income, marital status, telephone number and Medicaid or SSI eligibility.
- If I received the benefit of the Senior Rx subsidies and I was not eligible for the subsidy, I will refund to the Department of Human Resources all amounts paid on my behalf.
- That as a condition of, and for purposes of determining eligibility for this program, I authorize the Department of Human Resources to verify my eligibility including my income. This authorization is valid for a period of fourteen months from the date of my signature below.

I declare that the information in this application for the Senior Rx program is accurate to the best of my knowledge and ability.

_____
Applicant Signature

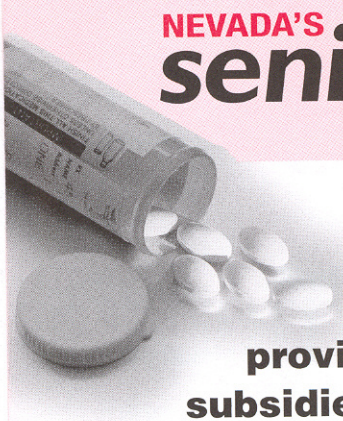
_____
Print Name *Date*

_____
Spouse Signature

_____
Print Name *Date*

Please note: *If someone other than the applicant/spouse signs, a copy (non-returnable) of a Power of Attorney or Letters of Guardianship must be attached.*

NEVADA'S seniorRx



The State of Nevada will provide insurance subsidies allowing you to obtain prescription medicines at significant discounts if you qualify:

- Age 62 or older
- Nevada resident for at least one year
- Not eligible for low-income Medicaid assistance
- Household income not over $21,500

The Benefits to You:

- No Premium
- No Deductible
- Copayments of $10 or $25

If you think you qualify complete the attached application and drop in any mail box. No postage necessary.

For more information:

1-800-262-7726

www.nevadaseniorrx.com

Outpatient Prescription Drug Insurance Enrollment Form

Underwritten by Fidelity Security Life Insurance Company, Kansas City, MO. **Policy No. PD-155**

Please complete enrollment form by typing or printing in ink.

Each applicant must complete and sign the member information section. If spouse is applying also, complete the second member information section on the back.

State of Nevada Senior Rx Prescription Drug Plan

Member's Name:_____

Social Security Number: _____/_____/_____

Address:_____

City:_____

State:_____ Zip:_____

Date of Birth _____/_____/_____ Sex: ❑Male ❑Female

Month Day Year

Phone Number:(_____)_____–_____

I understand and acknowledge that by applying for this group insurance I am also becoming a member of the United Associations of America Group Insurance Trust. The Trust is not the insurance company and has no responsibility for this insurance except to hold the master policy.

I understand and agree that the statements and answers in the application are complete and true as of the date I signed this application, and that this application becomes part of the contract of insurance. I also understand and agree that the insurance, if issued, will take effect on the effective date stated in the certificate provided this application has been accepted by the Company, the first premium has been paid in full, and that I am alive on the effective date.

Signature:_____Date:_____

A-00935

Each applicant must complete and sign the member information section. If spouse is applying also, complete the second member information section on the back.

(Information provided on this application is confidential. No person may publish, disclose or use any personal or confidential information contained on this application except for the purposes connected with the administration of this program.)

M-9022 07/01

Managed By: PRAM Insurance Services • 711 E. Imperial Hwy., Suite 100 • Brea, CA 92821 • 800-262-7726

Outpatient Prescription Drug Insurance Enrollment Form

Underwritten by Fidelity Security Life Insurance Company, Kansas City, MO. **Policy No. PD-155**

Please complete enrollment form by typing or printing in ink.

Each applicant must complete and sign the member information section.
If spouse is applying also, complete this member information section.

State of Nevada Senior Rx Prescription Drug Plan

Member's Name:_____

Social Security Number: _____/_____/_____

Address:_____

City:_____

State:_____ Zip:_____

Date of Birth _____/_____/_____ Sex: ❑Male ❑Female
Month Day Year

Phone Number:(_____)_____–_____

I understand and acknowledge that by applying for this group insurance I am also becoming a member of the United Associations of America Group Insurance Trust. The Trust is not the insurance company and has no responsibility for this insurance except to hold the master policy.

I understand and agree that the statements and answers in the application are complete and true as of the date I signed this application, and that this application becomes part of the contract of insurance. I also understand and agree that the insurance, if issued, will take effect on the effective date stated in the certificate provided this application has been accepted by the Company, the first premium has been paid in full, and that I am alive on the effective date.

Signature:_____Date:_____

A-00935

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If spouse is applying also, complete this member information section.

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M-9022 07/01

Managed By: PRAM Insurance Services • 711 E. Imperial Hwy., Suite 100 • Brea, CA 92821 • 800-262-7726

Requirements

A. Age: Applicant and spouse (if spouse is also applying) must be 62 years of age at the date of application.

B. Income: Includes income from all sources for both applicant and spouse. Total combined applicant and spouse income must be $21,500 per year or less.

C. Residency: Applicants must have lived continuously in Nevada for at least one year (12 consecutive months) prior to the date of application.

D. Eligibility for SSI/Medicaid: If you are eligible for SSI (Supplemental Security Income) in Nevada, you are also eligible for full Medicaid benefits, including prescription coverage, at no cost to you. Please contact the Social Security Administration at **1-800-772-1213** if you believe your situation matches one of the following:

1) Single person, under age 65 and disabled, annual income of less than $6,400, limited assets.
2) Single person, age 65 or older, annual income of less than $6,900, limited assets.
3) Single person, blind, annual income of less than $7,700, limited assets.
4) Married couple, age 65 or older, annual household income of less than $10,500, limited assets.

Important information about your application

A. You do not need to attach income or age verification to this application. However, you may be asked to provide such documentation at a later date.

B. Married couples need to submit only one application for both spouses.

C. You will be notified of eligibility status within 21 days of receipt of your application, unless the Department of Human Resources needs to request additional information to process your application.

D. Mail completed applications to:
State of Nevada
Senior Rx
P.O. Box 21230
Carson City, NV 89721-9909

Attach glue edge to this edge.

3261 Senior Rx
Dept. of Human Resources
Director's Office, Room 600
Carson City, Nevada 89701-3708

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 17 CARSON CITY NV

POSTAGE WILL BE PAID BY ADDRESSEE

STATE OF NEVADA
SENIOR RX
P.O. BOX 21230
CARSON CITY NV 89721-9909